IN THE CIRCUIT COURT OF TIPPAH COUNTY, MISSISSIPPI

STATE OF MISSISSIPPI **PLAINTIFF**

VS. **CAUSE NO. TK2017-163**

JAMES ALLEN HUGHEY **DEFENDANT**

DEFENDANT'S MOTION TO TAKE DEPOSITIONS

Pursuant to MISS. R. CRIM. P. 17.5, Defendant James Allen Hughey moves the Court to take depositions. For grounds, Hughey states:

1. Because there are exceptional circumstances in this case, it is in the interest of justice that depositions be taken. Hughey has a defense in this case that, at the time of the alleged burglary, his ammonia level was such that he would have had no knowledge of where he was or what he was doing and could not have entertained any criminal intent. This disabling level of ammonia is shown by the excerpt of the Tippah County Hospital Records, attached hereto as Exhibit "A," at Bates No. 24. In order to establish this level of ammonia and what effect it would have had upon Hughey, the deposition of Dr. John Preece should be taken.

2. In addition, medical records indicate that Hughey was severely beaten at the time of his arrest. These medical records are in the possession of a Memphis, Tennessee hospital. This hospital and its physicians are beyond the subpoena power of the Court. The five (5) page discharge summary from The Med in Memphis, Tennessee is attached as Exhibit "B." In order to have an explanation of these medical records and to describe the injury which Hughey received at the time of the beating, the deposition of his medical providers, Dr. Jane Elyse Henkel and Dr. John P. Sharpe, should be taken.

3. In the event Hughey's injuries can be substantiated, Hughey will have the basis for

00373223.WPD

EXHIBIT 3 tabbies

FILED THIS 2 DAY OF February 20 23
RANDY GRAVES, CIRCUIT CLERK
BY J White DC

moving to dismiss this case because of outrageous government conduct.

4. Hughey already has a pending civil suit arising out of the beating he received in the Tippah County Jail at the time of his arrest. *See* Complaint, attached hereto as Exhibit "C." However, Hughey has been unable to take depositions in the civil case because the federal court has continuously stayed the civil case until the disposal of this case. The most recent Order Denying Motion to Lift Stay is attached hereto as Exhibit "D."

5. Therefore, Defendant James Allen Hughey moves the Court to take the depositions of Dr. John Preece, Dr. Jane Elyse Henkel, and Dr. John P. Sharpe. If Dr. John Preece, Dr. Jane Elyse Henkel, or Dr. John P. Sharpe are unavailable, then Hughey moves the Court to take the depositions of substitute physicians who may be able to provide the requested medical information.

RESPECTFULLY SUBMITTED, this the 2nd day of February, 2023.

JAMES ALLEN HUGHEY, Plaintiff

By: Jim Waide

Jim Waide, MS Bar No. 6857
waide@waidelaw.com
WAIDE & ASSOCIATES, P.A.
332 North Spring Street
Tupelo, MS 38804-3955
Post Office Box 1357
Tupelo, MS 38802-1357
(662) 842-7324 / Telephone
(662) 842-8056 / Facsimile

Tyler L Moss, Esq.
tylerlmoss15@gmail.com
MOSS LAW FIRM, PLLC
Post Office Box 2279
Corinth, MS 38835
(662) 367-4628 / Telephone

ATTORNEYS FOR DEFENDANT

CERTIFICATE OF SERVICE

This will certify that undersigned counsel for Defendant has this day filed the above and foregoing **Motion to Take Depositions** with the Clerk of the Court, with copies of the same being mailed via email and U.S. Mail to:

Thad James Mueller, Esq.
Assistant District Attorney
District Attorneys Ofc-Dist 3
1301 Monroe Ave
Oxford, MS 38655-3750
Email: tmueller@thirdcircuitmsda.com

DATED, this the 2nd day of February, 2023.

JIM WAIDE

CERTIFICATE FOR BILLING RECORDS OF REGULARLY CONDUCTED ACTIVITY

Pursuant to the provisions of Rules 803(6) and 902(11) of the Federal Rule of Evidence, I hereby certify that I am the custodian of the billing records of the regularly conducted activities of Tippah County Hospital, or am otherwise qualified to certify to the authenticity, genuineness, and completeness of the attached records of James Allen Hughey, because I have firsthand knowledge about the making, maintenance, and storage of the texts and records thereof; that the records provided are what they are purported to be and are complete and accurate copies of the original records maintained by or on behalf of this entity; that the records were (a) made at or near the time of the occurrence of the matters set forth therein by, or from information transmitted by, a person with knowledge of those matters; (b) kept in the course of the regularly-conducted activity of this entity; and (c) were made by the entity as a regular practice in conducting its regularly conducted activities.

CUSTODIAN OR OTHER QUALIFIED WITNESS

By: Paula Null
Title: Clerk
Entity: Tippah County Hospital
Address of Entity: P.O. Box 499
Ripley MS 38663

Affirmed or sworn to and subscribed before me, this the 28th day of August, 2017.

(SEAL) STATE OF MISSISSIPPI NOTARY PUBLIC ID # 33495 CARMAN GOFORTH Commission Expires Feb. 1, 2019 TIPPAH COUNTY

Carman Goforth
Notary Public

My Commission Expires: 2/1/19

00316787.WPD

EXHIBIT
tabbies
A

07/18/2017
09:26

TIPPAH COUNTY HOSPITAL
Patient Account Detail
Service Dates:

0
ar_account_detail.template

Demographics

Account
10000304

Patient Info
HUGHEY JAMES ALLEN-
[redacted]
ASHLAND, MS 38603
SSN [redacted] Phone 662[redacted] Cell

Guarantor Info
HUGHEY JAMES ALLEN
[redacted]
ASHLAND, MS 38603
SSN [redacted] Phone [redacted] Cell

Stay Information

Admit Date	Admit Code	Stay Type	Service	Disch Date	Disch Code	DOB	Physician	Sex	MS
06/07/2017 E	11/EMER	3	E/R 10	06/08/2017 W	TFOTH	[redacted]	11126	PREECE JOIM	M

Billing Information

Cycle Code	Coll Code	Bill Sw	Cred Sw	Computed DRG	Receipted DRG
1					

Insurance Information

Primary Sw	Ins	Description	Subscriber	Contract Number	Group
Y	YA9	MAGNOLIA-AMBULANCE	HUGHEY JAMES ALLEN	603884353	
Y	YB9	MAGNOLIA -OP	HUGHEY JAMES ALLEN	603884353	
Y	YP9	MAGNOLIA - PHYS	HUGHEY JAMES ALLEN	603884353	

HIM Information

ICD9 Code	ICD10 Code	SNOMED Code	Diagnosis Description
	S2242XA		Multiple fractures of ribs, left side, initial
	S2241XA		Multiple fractures of ribs, right side, initi
	S3609XA		Other injury of spleen, initial encounter
	S3681XA		Injury of peritoneum, initial encounter
	K7460		Unspecified cirrhosis of liver
	F1010		Alcohol abuse, uncomplicated
	Y040XXA		Assault by unarmed brawl or fight, initia
	Y92148		Unspecified place in prison as the place
	S01311A		Laceration without foreign body of right

AR Date	Service Date	Type Tran	Code	ST	SC	LC	Chg/Rec Number	Qty	Description	CPT	NDC	Med Nec	Charge	Credit
06/07/2017		Chg / 20	55 / 300	3	10	1	2090003	1.00	CBC				$0.00	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000575	1.00	COMP MET	80053			$211.37	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000101	1.00	LIPASE	83690			$58.93	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000445	1.00	HIV ANTIBC	87389			$89.17	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000441	1.00	HEPATITIS	80074			$198.56	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000037	1.00	.CBC BLOO	85025			$98.04	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000009	1.00	AMMONIA	82140			$60.21	
06/07/2017		Chg / 20	55 / 300	3	10	1	2090005	1.00	PT/PTT				$0.00	
06/07/2017		Chg / 20	55 / 300	3	10	1	2000137	1.00	PROTHRO	85610			$39.17	

06/07/2017		Chg / 20	55 / 300	3	10	1	2000141	1.00 PTT	85730	$71.74
06/08/2017	06/07/2017	Chg / 40	61 / 351	3	10	1	4100001	1.00 CT HEAD W	70450	$1,694.00
06/08/2017	06/07/2017	Chg / 40	62 / 352	3	10	1	4100017	1.00 CT CHEST W	71250	$1,694.00
06/08/2017	06/07/2017	Chg / 40	62 / 352	3	10	1	4100059	1.00 CT ABDOMI	74176	$3,853.00
06/08/2017	06/07/2017	Chg / 40	62 / 352	3	10	1	4100011	1.00 CT CERVIC	72125	$1,690.92
06/08/2017		Chg / 15	36 / 450	3	10	1	1500013	1.00 EMERGEN	99285	$1,710.59
06/13/2017	06/07/2017	Chg / 85	8G / 540	3	10	1	8500007	1.00 ALS ET SER	A0427	$938.70
06/13/2017	06/07/2017	Chg / 85	8G / 540	3	10	1	8500013	1.00 ALS MILEAG	A0390	$18.90
06/19/2017								ER PHYSIC		
06/19/2017	06/07/2017	Chg / 16	SL / 981	3	10	1	1600009	1.00 ER PHYSIC	99285	$1,160.00
07/03/2017		Pay	IN				15201	YB9 MAGNI		$867.17
07/11/2017		Pay	IN				15355	YB9 MAGNI		$10,463.61
07/12/2017		Pay	IN				15380	YP9 MAGNI		$0.00
07/12/2017		Pay	IN				15391	YA9 MAGNI		$957.60

Total Charges:	13,597.90
Total Adjustments:	0.00
Less Payments:	12,468.38
AR Balance:	1,129.52
Bad Debt Balance:	0.00

Charge Summary

Summary Code	Revenue Code	Description	Amount	Days	Days Med Nec	Units
36	450	EMERG ROOM	1,710.59			1
55	300	LABORATORY (LAB)	837.79			10
61	351	CT SCAN/HEAD	1,694.00			1
62	352	CT SCAN/BODY	7,237.92			3
8G	540	AMBULANCE	957.60			2
SL	981	PROF FEES-E/R	1,160.00			1

Hospital Information

Name:	TIPPAH COUNTY HOSPITAL
Address 1:	1005 CITY AVENUE NORTH
Address 2:	
City/ST/Zip:	RIPLEY, MS 38663-8973
Phone#:	662-837-9221
Tax ID#:	646001350

P3

CERTIFICATE FOR MEDICAL RECORDS OF REGULARLY CONDUCTED ACTIVITY

Pursuant to the provisions Rules 803(6) and 902(11) of the Federal Rule of Evidence, I hereby certify that I am the custodian of the medical records of the regularly conducted activities of Tippah County Hospital, or am otherwise qualified to certify to the authenticity, genuineness, and completeness of the attached records of James Allen Hughey, because I have firsthand knowledge about the making, maintenance, and storage of the tests and records thereof; that the records provided are what they are purported to be and are complete and accurate copies of the original records maintained by or on behalf of this entity; that the records were (a) made at or near the time of the occurrence of the matters set forth therein by, or from information transmitted by, a person with knowledge of those matters; (b) kept in the course of the regularly-conducted activity of this entity; and (c) were made by the entity as a regular practice in conducting its regularly conducted activities.

CUSTODIAN OR OTHER QUALIFIED WITNESS
By: Paula Reed
Title: Clerk
Entity: Tippah County Hospital
Address of Entity: P.O. Box 499
Ripley, MS 38663

Affirmed or sworn to and subscribed before me, this the 28th day of August, 2017.

(SEAL)

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 33495 CARMAN GOFORTH Commission Expires Feb. 1, 2019 TIPPAH COUNTY

Carman Goforth
Notary Public

My Commission Expires: 2/1/19

903 16737.WPD

Tippah County Hospital

Name: HUGHEY JAMES ALLEN DOB: [redacted]
MR: 25866

Triage

JENKINS MARSHA 06/07/2017 22:24

Does Patient Have a Fever: No
Patient Symptoms/Conditions: Joint pain, Muscle pain, facial pain
Patient Exposure Risk in Last 30 Days: Denies exposure risk
Potential Infection Risk Assessment: Criteria NOT MET
ED Arrival Date/Time: 06/07/2017 22:25
Triage Date/Time: 06/07/2017 22:25
Time Physician Notified: 22:26
Is This A Trauma Case: Yes
Distress: Mild Distress
Triage Level: 3 - Urgent
Date of Symptom Onset: 06/07/2017
Time of Symptom Onset: tonight
Brief Description
INTOXICATED. INVOLVED IN ALTERCATION AT SOME POINT PRIOR TO GOING TO JAIL. C/O "PAIN ALL OVER". BRUISING TO RT SIDE OF FACE.
Are You on Hospice: No
Work Relatedness: Not Work Related
Treatment Prior to Arrival: See EMS Report, Cardiac monitoring, IV, Oxygen
Means of Arrival: EMS Ambulance
GCS Assessment: Yes
Eyes: 4 - Open spontaneously
Verbal: 4 - Confused
Motor: 6 - Obeys commands for movement
Neuro - GCS Total Score: 14
Temperature: 98.1 F (36.7 C)
Pulse: 100 bpm
Respiration: 16 breaths/min
Blood Pressure: 104/51 ,
O2 Saturation: 97 %
O2 Delivery Method: O2 Cannula
O2 L/Min: 2
Height: 67 inches (5'7", 170.18 cm)
Weight: 187 lbs (84.82 kg, 84821.7 g)
BMI: 29.29 kg/m2
BSA: 2 m2
Pain Location: Arm: left upper, Head: WHOLE HEAD, Face: RT FACE
Additional Pain Scales: Wong-Baker
Wong Baker: 4
Pain Quality: ACHING
Onset Mode: Gradual
Relieving Factors: None
Clinical Observation of Pain: Relaxed, calm expression
Tetanus Vaccination Status: Unknown
Appearance Common Findings: Age Appropriate Behavior, Alert, Poorly Groomed, Mild Distress
Visual Acuity Evaluated: No
History Reported By: Patient, EMS Provider.
Previous Admission to Hospital: No
Preferred Language for Healthcare: English

PS

Screening

JENKINS MARSHA 06/07/2017 22:24

TIMI Screen: No
Begin Abuse Screen: No
Begin Suicide Screen: No
Begin Fall Risk Screen: No
Begin Nutrition Screen: No
Begin Tobacco Screen: Yes
Tobacco Use: Currently uses tobacco: smokes, Smoke amount / frequency: 1 PPD
Tobacco Cessation Readiness: Not ready
Tobacco Cessation Material: Information given, Patient refused/not interested
Begin Alcohol Use Screen: Yes
Alcohol Intake: Frequent Use, Binge Drinking
Alcohol Treatment Readiness: Not ready
Begin Illicit Drug Use Screen: No
Begin CIWA Assessment: No
Begin COWS Assessment: No
Begin Occupation Screen: No
Cultural / Religious Considerations Regarding Care: No
Begin Sepsis Screen: No
Begin Tuberculosis Screen: No
Isolation Screen: No
Sexual Development Assessment: Normal sex characteristics

Intervention

JENKINS MARSHA 06/07/2017 22:24

General: Bed in low position, IV, Side rails up x 2, Armband on
Labs: None
Medication: None
Respiratory: None
Length of Triage: 5 to 10 minutes
Triage Disposition: To room 1B
Opportunity given to answer all questions: Yes
Person Assuming Patient Care: Not Applicable
Patient Status: Ready for Provider

Skin

JENKINS MARSHA 06/07/2017 22:35
Skin Exam Common Findings: Normal Turgor
Skin Temperature/Moisture: Warm and Dry
Oral Mucosa: Normal Color
Normal Nails: Normal - All Nails
Braden Scale - Activity: 4 - Walks frequently
Braden Scale - Friction and Shear: 3 - No apparent problem
Braden Scale - Mobility: 4 - No limitations
Braden Scale - Nutrition: 4 - Excellent, eats most of every meal
Braden Scale - Sensory Perception: 4 - No impairment
Braden Scale Total Score: 19

HEMATOMA TO RT SIDE OF FACE. ALTERCATION. LOC UNKNOWN. PT INTOXICATED AND DOES NOT REMEMBER INCIDENT.

HEENT

JENKINS MARSHA 06/07/2017 22:35
Oral Mucosa: Normal Color

Musculoskeletal

JENKINS MARSHA 06/07/2017 22:35
Complaints: Joint pain, Joint stiffness, Muscle pain, Muscle stiffness
Pain Location: Head / Neck, Torso, Upper Extremities
Ambulation: Close supervision, Shuffling gait

Tippah County Hospital

Name: HUGHEY JAMES ALLEN DOB: [redacted]
MR: 25866

History of Present Illness
PREECE JOHN DO 06/08/2017 01:02
DATE / TIME Seen by Provider: 06/07/2017 23:30
Chief Complaint: Multiple System Trauma, Altercation while incarcerated.
Means of Arrival: EMS Ambulance
History Reported By: Patient, Family
Previous Medical Records: Not Available
Trauma Timeframe: 6-8 Hour(s) Ago, Date 6/7/17
Force of Impact: Blunt trauma by another person to head, chest, and abdomen.
Symptoms:
Include: Confusion, Altered Level of Consciousness, Localized Pain
Do not include: Difficulty Breathing, Localized Paralysis
Onset: Immediately After the Injury
Severity: Moderate
Relieving Factors: None Reported

Patient with reported altercation that left him initially unconscious but quickly regain consciousness and complained of head and abdominal pain. He had been beat by another inmate. Altercation not witnessed. This was afternoon of 6/7/17. Patient's main complaint is abdominal pain at this time. Of note, he has a history of cirrhosis 2/2 EtOH abuse and IDDM. He takes lactulose but is not compliant per family.

Review of Systems
PREECE JOHN DO 06/08/2017 01:02
ROS Otherwise Negative: Complete Review Otherwise Negative

Physical Exam
Constitutional
PREECE JOHN DO 06/08/2017 01:02
Appearance Common Findings: Alert, Oriented to Person/Place/Time
Level of Consciousness: Alert, GCS = 15
Glasgow Coma Scale: GCS = 15

Patient with times of confusion but when prompted multiple times will answers que stions appropriately.

Head
PREECE JOHN DO 06/08/2017 01:02
Head Common Findings: No Skull Deformity, Scalp lac behind right ear with multiple bruises to right side of face. TMJ
Facial Trauma Detail: Facial Bones Intact, Orbits Intact, Facial Bruising, Facial Bone Tenderness, Bony Step Off Noted, Open and close mouth appropriately with correct approximation of teeth. No bone crepitus.

Eyes
PREECE JOHN DO 06/08/2017 01:02
Eyelids: No Erythema, No Swelling
Conjunctiva Detail: Bilateral - Normal Conjunctiva
Sclera: Non-Icteric
Cornea: Bilateral - Normal Cornea
Iris / Pupils: Bilateral - Normal Iris/Pupil

ENT
PREECE JOHN DO 06/08/2017 01:02
Ear Exam Common Findings: Right - TM Red
Hearing Grossly Intact - Bilateral; Blood noted in R ear canal

Nasal Exam Common Findings: Normal Nose/Nasal Mucosa/No Nasal Discharge
Oropharynx Common Findings: Normal Oropharynx, Normal Pharynx, No Lesions

Neck
PREECE JOHN DO 06/08/2017 01:02
Neck Exam Common Findings: Normal Range of Motion, Normal Appearance, No Neck Tenderness

Thorax and Lungs
PREECE JOHN DO 06/08/2017 01:02
Normal Chest Inspection: Normal Shape, Symmetric, No Deformity, Normal Chest Expansion, No Bruising, No Signs of Injury
Chest Auscultation: CTA b/l

Cardiovascular
PREECE JOHN DO 06/08/2017 01:02
Cardiac Exam Common Findings: Tachycardic, no murmurs appreciated.
Arterial Exam Common Finding: Pulses Intact and Symmetric UE/LE

Abdomen
PREECE JOHN DO 06/08/2017 01:02
Bowel Sound Quality: Hypoactive
Tenderness/Guarding/Rebound: Moderate Tenderness
Tenderness Location: Left Upper Quadrant, Diffuse but worse in LUQ
Abdominal Rigidity: No Rigidity
Liver Details: Non-Palpable
Spleen Size: Enlarged
Kidney Exam: Not Enlarged, No CVA Tenderness

Genitourinary
PREECE JOHN DO 06/08/2017 01:02
Male GU Exam: Normal exam, no blood noted at urethral meatus.

Digital Rectal Exam
PREECE JOHN DO 06/08/2017 01:02
Normal Digital Rectal Exam: Normal Digital Rectal Exam, No blood noted.
Anal Sphincter: Normal Sphincter Tone

Skin
PREECE JOHN DO 06/08/2017 01:02
Skin Exam Common Findings: Skin Exam Normal Except As Noted, Negative Cullen's or Grey Turner's sign, only bruising noted was to right face.
Skin Temperature/Moisture: Warm and Dry

Neurologic
PREECE JOHN DO 06/08/2017 01:02
Neuro Exam Common Findings: Strength Normal All Extremities, Moves All Extremities
Normal Sensory Exam: Normal Except as Noted
Normal Motor Exam: Normal Strength - All Extremities
Normal Reflexes: DTRs Normal

Psychiatric
PREECE JOHN DO 06/08/2017 01:02
Neuropsych Common Findings: Alert/Normal Affect

ED Course

PREECE JOHN DO 06/08/2017 01:02
Initial Impression: Multiple System Trauma
Current Condition: Moderate
ED Testing: CBC, Comprehensive Metabolic Panel, Urinalysis, Head CT, Cervical Spine CT, Chest CT, Abdominopelvic CT
Additional Treatments: NS bolus x2L
Treatment Response: Unchanged Condition

Assessment

PREECE JOHN DO 06/08/2017 01:02
Final Impression: Splenic injury
Current Condition: Hemoperitoneum

Plan

PREECE JOHN DO 06/08/2017 01:02
Diagnostic Plan: Trauma Surgery Consultation
Disposition: Transfer to The Med, By air
Case Discussion: Discussed with Patient, Discussed with Family
Critical Care Time: 135-164 minutes

Patient with multiple system trauma, CT head neg, CT c-spine neg, CT chest neg. CT scans revealed splenic subcapsular hematoma with hemoperitoneum (unknown grade). He has received 2L NS bolus. Hgb at 8.8, but coag wnl despite being a cirrhotic. Spoke with Dr. Weatherly at the Med and he has accepted the patient in transfer. Current Vital signs at time of dispo were BP 96/55 HR 99 O2 Sat 94% (2L) Temp 98.1F

Tippah County Hospital

Name: HUGHEY JAMES ALLEN DOB: [redacted]
MR: 25866

Disposition

PREECE JOHN DO 06/08/2017 01:30

Disposition: Transfer to The Med

Patient stable prior to transfer. Family informed of situation. Patient is full code at this time.

Tippah County Hospital

Name: HUGHEY JAMES ALLEN DOB: [redacted]
MR: 25866

History of Present Illness

Major Trauma

PRERCE JOHN DO 06/08/2017 01:02
DATE / TIME Seen by Provider: 06/07/2017 23:30
Chief Complaint: Multiple System Trauma, Altercation while incarcerated.
Means of Arrival: EMS Ambulance
History Reported By: Patient, Family
Previous Medical Records: Not Available
Trauma Timeframe: 6-8 Hour(s) Ago, Date 6/7/17
Force of Impact: Blunt trauma by another person to head, chest, and abdomen.
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Include: Confusion, Altered Level of Consciousness, Localized Pain
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Allergies

MARSHA JENKINS 00:00
No Known Drug Allergies: Normal DRUG Active

Home Medications

Home Medications

00:00
BOTTLES NOT AVAILABLE

PFSH

Drug Use History

00:00
Has had tobacco screening performed. Screening date: 06/07/2017.
Current every day smoker.

Medical History

00:00
No documentation for this section.

Review of Systems

PRERCE JOHN DO 06/08/2017 01:02
ROS Otherwise Negative: Complete Review Otherwise Negative

Vital Signs

Vital Signs/Height/Weight/O2 Therapy

(JENKINS M) 06/07/2017 22:24
Weight 187 lbs 84.82 kg 84821.7 g
BMI 29.29
BSA 2.00
Height 67.00 inches 170.2 cm

Temperature 98.1 F 36.7 C
Respiration 16
Pulse 100
O2 Sat 97 %
O2 L/M 2
Method O2 Cannula
Blood Pressure 104/51

Physical Exam

Constitutional

PREECE JOHN DO 06/08/2017 01:02
Appearance Common Findings: Alert, Oriented to Person/Place/Time
Level of Consciousness: Alert, GCS = 15
Glasgow Coma Scale: GCS = 15

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Facial Trauma Detail: Facial Bones Intact, Orbits Intact, Facial Bruising, Facial Bone Tenderness, Bony Step Off Noted, Open and close mouth appropriately with correct approximation of teeth. No bone crepitus.

Eyes

PREECE JOHN DO 06/08/2017 01:02
Eyelids: No Erythema, No Swelling
Conjunctiva Detail: Bilateral - Normal Conjunctiva
Sclera: Non-Icteric
Cornea: Bilateral - Normal Cornea
Iris / Pupils: Bilateral - Normal Iris/Pupil

ENT

PREECE JOHN DO 06/08/2017 01:02
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Neck

PREECE JOHN DO 06/08/2017 01:02
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Thorax and Lungs

PREECE JOHN DO 06/08/2017 01:02
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Chest Auscultation: CTA b/l

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Digital Rectal Exam
PREECE JOHN DO 06/08/2017 01:03
Normal Digital Rectal Exam: Normal Digital Rectal Exam, No blood noted.
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Additional Treatments: NS bolus x2L
Treatment Response: Unchanged Condition

Medications Administered
00:00
No documentation for this section.

Ancillary Orders/Results
LABORATORY
06/07/2017 23:43

.CBC BLOOD COUNT Scheduled:06/07/2017 23:48 PREECE JOHN

Procedure
00:00
No documentation for this section.

New Prescriptions
Home Medications
00:00
BOTTLES NOT AVAILABLE

Medical Decision Making
Major Trauma
PREECE JOHN DO 06/08/2017 01:02
Final Impression: Splenic injury
Current Condition: Hemoperitoneum
Diagnostic Plan: Trauma Surgery Consultation
Disposition: Transfer to The Med, By air
Case Discussion: Discussed with Patient, Discussed with Family
Critical Care Time: 135-164 minutes

Patient with multiple system trauma, CT head neg, CT c-spine neg, CT chest neg. CT scans revealed splenic subcapsular hematoma with hemoperitoneum (unknown grade). He has received 2L NS bolus. Hgb at 8.8, but coag wnl despite being a cirrhotic. Spoke with Dr. Weatherly at the Med and he has accepted the patient in transfer. Current Vital signs at time of dispo were BP 96/55 HR 99 O2 Sat 94% (2L) Temp 98.1F

Impression
PREECE JOHN DO 06/08/2017 01:33
Splenic hematoma: Entered:06/08/2017 Last Addressed:06/08/2017
Multiple trauma: Entered:06/08/2017 Last Addressed:06/08/2017
PREECE JOHN DO 06/08/2017 01:34
Acute blood loss anemia: Entered:06/08/2017 Last Addressed:06/08/2017

TIPPAH COUNTY HOSPITAL

PROBLEM LIST

From: First Visit To: Today

HUGHEY JAMES ALLEN AGE: 46 SEX: M MRN: 25866

ALLER: No Known Drug Allergies

Entered	Problem	Type	Addressed	Resolved
06/07/17 22:41 JP	Altercation		06/08/17	
06/08/17 01:33 JP	Splenic hematoma		06/08/17	
	Multiple trauma		06/08/17	
01:34 JP	Acute blood loss anemia		06/08/17	

LabCorp

Patient Report

Specimen ID: 159-449-6333-0
Control ID: B0060559038

Acct #: 23614235 Phone: (662) 837-2276 Rpt: 00

HUGHEY, JAMES A.

Tippah County Hospital
1005 City Avenue
RIPLEY MS 38663

Patient Details
DOB [redacted]
Age(y/m/d): 045/08/07
Gender: M SSN:
Patient ID:

Specimen Details
Date collected: 06/08/2017 0016 Local
Date received: 06/08/2017
Date entered: 06/08/2017
Date reported: 06/09/2017 1806 ET

Physician Details
Ordering: J PREECE
Referring:
ID:
NPI:

General Comments & Additional Information
Alternate Control Number: B0060559038

Alternate Patient ID: Not Provided

Ordered Items
Hepatitis Panel (4); Panel 083935

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Hepatitis Panel (4)					
Hep A Ab, IgM	Negative			Negative	01
HBsAg Screen	Negative			Negative	01
Hep B Core Ab, IgM	Negative			Negative	01
Hep C Virus Ab	<0.1		s/co ratio	0.0 - 0.9	01
				Negative: < 0.8	
				Indeterminate: 0.8 - 0.9	
				Positive: > 0.9	
The CDC recommends that a positive HCV antibody result be followed up with a HCV Nucleic Acid Amplification test (550713).					
Panel 083935					
HIV Screen 4th Generation wRfx	Non Reactive			Non Reactive	01

01 MB LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-1935
Dir: Brian Ragland, MD

For inquiries, the physician may contact Branch: 972-566-7500 Lab: 205-581-3500

Date Issued: 06/11/17 1039 ET

FINAL REPORT

Page 1 of 1

LabCorp

Patient Report

Specimen ID: 159-449-6333-0
Control ID: B0060559038

Acct #: 23614235 Phone: (662) 837-2276 Rte: 00

HUGHEY, JAMES A.

Tippah County Hospital
1005 City Avenue
RIPLEY MS 38663

Patient Details
DOB: [redacted]
Age(y/m/d): 045/08/07
Gender: M SSN:
Patient ID:

Specimen Details
Date collected: 06/08/2017 0016 Local
Date received: 06/08/2017
Date entered: 06/08/2017
Date reported: 06/09/2017 1806 ET

Physician Details
Ordering: J PREECE
Referring:
ID:
NPI:

General Comments & Additional Information
Alternate Control Number: B0060559038

Alternate Patient ID: Not Provided

Ordered Items
Hepatitis Panel (4); Panel 083935

	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Hepatitis Panel (4)					
Hep A Ab, IgM	Negative			Negative	01
HBsAg Screen	Negative			Negative	01
Hep B Core Ab, IgM	Negative			Negative	01
Hep C Virus Ab	<0.1		s/co ratio	0.0 - 0.9	01
			Negative:	< 0.8	
			Indeterminate:	0.8 - 0.9	
			Positive:	> 0.9	

The CDC recommends that a positive HCV antibody result be followed up with a HCV Nucleic Acid Amplification test (550713).

Panel 083935

HIV Screen 4th Generation wRfx	Non Reactive			Non Reactive	01

01 MB LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-1935
Dir: Brian Ragland, MD

For inquiries, the physician may contact Branch: 972-566-7600 Lab: 205-581-3500

Date Issued: 06/11/17 1039 ET

FINAL REPORT

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PREECE JOHN ATT: SEC: PRI:
PAT PHONE: (662) [redacted]

---PROCEDURE--- HIV ANTIBODY SCREEN ORDER # 2429

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2320	6/07/17 2332	6/07/17 2332	6/11/17 0954	6/11/17 0954
JP	ER	DS	JB	JB

HIV ANTIBODY SCREEN
SEE SEPARATE REFERENCE LAB REPORT

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PREECE JOHN ATT: SEC: PRI:
PAT PHONE: [redacted]

ORDER # 2430

---PROCEDURE--- HEPATITIS PROF ACUTE UNDI				
--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2321	6/07/17 2333	6/07/17 2333	6/11/17 0955	6/11/17 0955
JP	ER	DS	JB	JB

HEPATITIS PROF ACUTE UNDI
SEE SEPARATE REFERENCE LAB REPORT

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PREECE JOHN ATT: SEC: PRI:
PAT PHONE: [redacted]

---PROCEDURE--- CBC ORDER # 2432

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2321	6/07/17 2331	6/07/17 2331	6/07/17 2348	6/07/17 2348
JP	ER	DS	DS	DS

COMPLETE BLOOD COUNT

[WB]	WBC	11.91	H	x10^3/ul	(L=5.40	H=10.20	)]
[RB]	RBC	3.59		x10^6/ul	(L=3.50	H=6.00	)]
[HG]	HEMOGLOBIN	8.8	L	g/dL	(L=12.0	H=18.0	)]
[HC]	HEMATOCRIT	29.5	L	%	(L=36.0	H=54.0	)]
[MV]	MCV	82.2	L	fL	(L=83.1	H=93.5	)]
[MH]	MCH	24.5	L	pg	(L=27.3	H=31.7	)]
[MC]	MCHC	29.8	L	g/dL	(L=32.3	H=34.7	)]
[PL]	PLATELETS	125	L	K/uL	(L=150	H=450	)]
[N%]	%EG	74.6		%	(L=42.2	H=75.2	)]
[L%]	%LYMPH	11.9	L	%	(L=20.5	H=51.1	)]
[M%]	%MONO	11.5	H	%	(L=1.7	H=9.3	)]
[E%]	%EOS	1.1		%	(L=0.0	H=6.0	)]
[B%]	%BASO	0.5		%	(L=0.0	H=2.0	)]
[IG]	IG	0.4		%	(L=0.0	H=0.4	)]
(	MANUAL DIFF	NOT_INDICATED					
(	RBC MORPH						

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R
ORD: PREECE JOHN ATT:				SEC:		PRI:		
PAT PHONE: [redacted]								

---PROCEDURE--- COMP METABOLIC PANEL CMP ORDER # 2433

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2321	6/07/17 2331	6/07/17 2331	6/07/17 2349	6/07/17 2349
JP .ER		DS	DS	DS

COMPREHENSIVE METABOLIC PANEL

[GL]	GLUCOSE	170	H	mg/dL	(L=70	H=106	)]
[ur]	BUN	5	L	mg/dL	(L=7	H=20	)]
[CR]	CREATININE	1.0		mg/dL	(L=0.5	H=1.2	)]
[NA]	SODIUM	136		mmol/L	(L=136	H=144	)]
[K]	POTASSIUM	4.2		mmol/L	(L=3.5	H=4.9	)]
[CL]	CHLORIDE	101		mmol/L	(L=98	H=110	)]
[CO]	CO2	17	L	mmol/L	(L=23	H=34	)]
[CA]	CALCIUM	8.2	L	mg/dL	(L=8.3	H=10.3	)]
[TP]	TOTAL PROTEIN	7.3		mg/dL	(L=6.0	H=8.0	)]
[AL]	ALBUMIN	3.8		g/dL	(L=3.5	H=4.7	)]
[go]	SGOT/AST	68	H	U/L	(L=15	H=46	)]
[gp]	SGPT/ALT	47		U/L	(L=11	H=51	)]
[AP]	ALKALINE PHOS	116		U/L	(L=48	H=124	)]
[TB]	TOTAL BILI	1.0		mg/dL	(L=0.2	H=1.3	)]
[	ANION GAP	22					]
[	AGE	45		yrs			]
[	NON-AA GFR	81		mL/min			]
[	AFR AMER GFR	98		mL/min			]

GFR INTERPRETATION

RISK FACTORS for kidney disease (e.g. diabetes, high blood pressure, family history, older age, ethnic group)

STAGE	DESCRIPTION	GFR
1	Kidney damage (protein in the urine) and normal GFR	More than 90
2	Kidney damage and mild decrease in GFR	60 to 89
3	Moderate decrease in GFR	30 to 59
4	Severe decrease in GFR	15 to 29
5	Kidney failure (dialysis or kidney transplant needed)	Less than 15

Results for GFR on patients <18 years of age are invalid.

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PREECE JOHN ATT: SEC: PRI:
PAT PHONE: [redacted]

---PROCEDURE--- LIPASE ORDER # 2434

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2321	6/07/17 2331	6/07/17 2331	6/07/17 2348	6/07/17 2348
JP	.ER	DS	DS	DS

[LI]	LIPASE	226	U/L	(L=23	H=300	)]

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PREECE JOHN ATT: SEC: PRI:
PAT PHONE: [redacted]

---PROCEDURE--- AMMONIA ORDER # 2437

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/07/17 2353	6/07/17 2356	6/07/17 2356	6/08/17 0041	6/08/17 0041
JP	.ER	DS	DS	DS

[AM]	AMMONIA	103.0	H	umol/L	(L=9.0	H=30.0)]

TIPPAH COUNTY HOSPITAL
1005 City Avenue North
Ripley, MS 38663
CLIA#25D0316569

----PATIENT NAME----	SEX	AGE	BIRTH	ADMIT	M/R#	PATIENT#	RM/LOC	TYPE
HUGHEY JAMES ALLEN	M	45	[redacted]	060717	25866	10000304	ER1b	E/R

ORD: PRESCE JOHN ATT: SEC: PRI:
PAT PHONE: [redacted]

ORDER # 2438

---PROCEDURE---	PT/PTT						
--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---			
6/07/17 2353	6/07/17 2356	6/07/17 2356	6/08/17 0041	6/08/17 0041			
JP	.ER	DS	DS	DS			
[PT]	PROTIME	12.3	Secs				
[@I]	INR	1.18 H		(L=0.87	H=1.14		
[AP]	APTT	24.5	Secs	(L=22.0	H=32.0		

PROTIME/INR INTERPRETATION

LOW INTENSITY THERAPY	1.5	- 2.0
MOD. INTENSITY THERAPY	2.0	- 3.0
HIGH INTENSITY THERAPY	2.5	- 3.5

Tippah County Hospital
1005 City Avenue North
Ripley, MS 38663

-------NAME-------- NUMBER SEX AGE ADMIT DISC. XRAY# F/C TYPE
HUGHEY JAMES ALLEN 10000304 M 45 6/07/17 25866
DATE OF BIRTH: [redacted] MR# 25866 PH#: [redacted] ER Ib

LOCATION. TRANSCRIBED: 06/08/17 15 004
CT HEAD W/O 70450 COMPLETED: 560
{Reason for Test: Trauma

PHYSICIAN: PREECE JOH

RADIOLOGY REPORT

Final Report

CT head without contrast

Date of Exam: June 07 2017

HISTORY
{Reason for Test: Trauma Relevant Clinical Information

COMPARISON
None

FINDINGS
The brain parenchyma, ventricular system, and subarachnoid spaces appear normal. There is no midline shift or mass effect. There are no intra- or extra-axial hemorrhages.
The calvarium is intact. The imaged paranasal sinuses are clear.

IMPRESSION
Negative exam.

Electronically signed by: Wm Henson (Jun 08, 2017 00:12:58)

Electronically Signed By:
William C. Henson, MD
Date/Time: 06/08/17 00:12

Tippah County Hospital
1005 City Avenue North
Ripley, MS 38663

-------NAME------- NUMBER SEX AGE ADMIT DISC. XRAY# E/C TYPE
HUGHEY JAMES ALLEN 10000304 M 45 6/07/17 25866
DATE OF BIRTH: [redacted] M/R# 25866 PH#: [redacted] RM ER1b

LOCATION: TRANSCRIBED: 06/08/17 30 004
CT CHEST W/O CONTRAST 71250 COMPLETED:06/08/17 17 CR 562
(Reason for Chest: Trauma

PHYSICIAN: PREECE JOH

RADIOLOGY REPORT

Final Report

CT chest, abdomen, and pelvis without contrast

Date of Exam: June 07 2017

HISTORY
(Reason for Chest: Trauma Relevant Clinical Information

COMPARISON
None

FINDINGS
Heart and great vessels appear normal. No chest adenopathy. Lungs are clear of infiltrate. Right pleural effusion is tiny. No left pleural effusion. No pneumothoraces.
Liver surface is nodular. There are small stones in the gallbladder. Abnormal appearance with subtle heterogeneity. Additionally, there is a heterogeneous subcapsular fluid collection. Findings are compatible with splenic injury and subcapsular hemorrhage.
Pancreas, adrenal glands, kidneys, urinary bladder, and prostate gland appear normal. Abdomen has moderate scattered hemoperitoneum. There is no adenopathy or free air in the abdomen or pelvis.
There are fractures posteriorly of the left 9th, 10th, and 11th ribs. There fractures posteriorly of the right 8th, 9th, and 10th ribs. There is no other fracture.

IMPRESSION

1. Findings consistent with splenic injury, splenic subcapsular hematoma, and moderate scattered hemoperitoneum. Further evaluation is limited secondary to lack of IV contrast.
2. Tiny right pleural effusion.
3. Left 9th through 11th rib fractures and right 8th through 10th rib

fractures,
4. Hepatic surface nodularity suggesting cirrhosis.
5. Cholelithiasis.

Electronically signed by: Wm Henson (Jun 08, 2017 00:27:38)

Electronically Signed By:
William C. Henson, MD
Date/Time: 06/08/17 00:27

Tippah County Hospital
1005 City Avenue North
Ripley, MS 38663

--------NAME-------- NUMBER SEX AGE ADMIT DISC. XRAY# F/C TYPE
HUGHEY JAMES ALLEN 10000304 M 45 6/07/17 25866

DATE OF BIRTH: [redacted] MRN 25866 PH#: [redacted] RM ER1b

LOCATION: TRANSCRIBED: 06/08/17 30 004
CT ABDOMEN/PELVIS W/O 74176 COMPLETED:06/08/17 17 CR 563
(Reason for Abdomen: Trauma, Abdominal pain RUQ

PHYSICIAN: PREECE JOH

RADIOLOGY REPORT

Final Report

CT chest, abdomen, and pelvis without contrast

Date of Exam: June 07 2017

HISTORY
(Reason for Chest: Trauma Relevant Clinical Information

COMPARISON
None

FINDINGS
Heart and great vessels appear normal. No chest adenopathy. Lungs are clear of infiltrate. Right pleural effusion is tiny. No left pleural effusion. No pneumothoraces.
Liver surface is nodular. There are small stones in the gallbladder. Abnormal appearance with subtle heterogeneity. Additionally, there is a heterogeneous subcapsular fluid collection. Findings are compatible with splenic injury and subcapsular hemorrhage.
Pancreas, adrenal glands, kidneys, urinary bladder, and prostate gland appear normal. Abdomen has moderate scattered hemoperitoneum. There is no adenopathy or free air in the abdomen or pelvis.
There are fractures posteriorly of the left 9th, 10th, and 11th ribs. There fractures posteriorly of the right 8th, 9th, and 10th ribs. There is no other fracture.

IMPRESSION

1. Findings consistent with splenic injury, splenic subcapsular hematoma, and moderate scattered hemoperitoneum. Further evaluation is limited secondary to lack of IV contrast.
2. Tiny right pleural effusion.
3. Left 9th through 11th rib fractures and right 8th through 10th rib

fractures.
4. Hepatic surface nodularity suggesting cirrhosis.
5. Cholelithiasis.

Electronically signed by: Wm Henson (Jun 08, 2017 00:27:38)

Electronically Signed By:
William C. Henson, MD
Date/Time: 06/08/17 00:27

Tippah County Hospital
1005 City Avenue North
Ripley, MS 38663

NAME	NUMBER	SEX	AGE	ADMIT	DISC.	XRAY#	F/C	TYPE
HUGHEY JAMES ALLEN	10000304	M	45	6/07/17		25866		

DATE OF BIRTH: [redacted] M/R# 25866 PH#: [redacted] RM ER1b

LOCATION: TRANSCRIBED: 06/08/17 16 004
CT CERVICAL SPINE W/O 72125 COMPLETED: 564
(Spine Proced Reason: Trauma

PHYSICIAN: PREECE JOH

RADIOLOGY REPORT

Final Report

CT cervical spine

Date of Exam: June 07 2017

TECHNIQUE
(Spine Proced Reason: Trauma Relevant Clinical Information

HISTORY
CT cervical spine without contrast

FINDINGS
Normal anterior cervical alignment. No prevertebral edema. There is mild scattered degenerative change but no fracture or dislocation. Craniocervical junction appears normal.

IMPRESSION
Mild degenerative change with no evidence of trauma.
Electronically signed by: Wm Henson (Jun 08, 2017 00:14:00)

Electronically Signed By:
William C. Henson, MD
Date/Time: 06/08/17 00:14

B

Tippah County Hospital

Patient Condition and Certification of Transfer

[redacted] 06/07/17 [redacted]

Address Stamp / Patient Label

Tippah County Hospital is required to provide any presenting patient with a medical screening examination to determine whether an emergency medical condition exists and to provide necessary stabilizing care within its capabilities for emergency medical conditions, WITHOUT REGARD TO MEANS OR ABILITY TO PAY. Tippah County Hospital participates in Medicare.

1 PATIENT CONDITION AND CERTIFICATION FOR TRANSFER:

- ☐ There is no reasonable likelihood of deterioration from or during transfer; stable for transfer.
- ☐ The patient may be at risk for deterioration from or during transfer.
- ☐ The patient is pregnant with contractions.

Based upon my examination of the patient and the information available to me at the time of transfer, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

Transfer Orders Rx Please

Physician [redacted] Date & Time 6/8/17 1338

2 REASON FOR TRANSFER:

☒ For equipment or services not available at this facility:

(list) Laceration Spleen / Trauma

☐ Patient-initiated request for transfer. Services are available here and offered to patient, who wishes of their own volition and request to be transferred.

3 BENEFITS OF TRANSFER:

☒ Higher level of care ☒ Specialized service/specialist ☐ Other Trauma

4 RISKS OF TRANSFER:

☒ Worsening of pts EMC or death en route ☐ Loss of IV access or airway control en route

☐ Additional pain/trauma to existing injuries ☐ Other

5 HOSPITAL ACCEPTANCE:

Destination hospital: Me Med Facility Representative: [redacted] Time:

Accepting MD: Dr. Moriarty Time: Report called to: Rhonda Time:

6 DISCHARGE VITALS:

Time: 0130 BP: 95/60 Pain Level: 7 Pulse: 98

Resp: 20 Temp: 98 SaO2: 96%0

Copies of record sent: ☒ Chart ☐ Film ☐ Radiology ☒ Front Sheet ☒ CCDA Document ☒ Med Rec

Equipment: VIOM for O2 Allergies: NKDA

EYES	VERBAL	MOTOR
4 Open	5 Oriented	6 Obeys
3 Open	4 Confused	5 Localizes
2 To Pain	3 Words	4 Withdrawal
1 None	2 Sounds	3 Flexion
	1 None	2 Extension
		1 None

Total = 12

7 MODE OF TRANSPORT:

☐ ALS Ambulance ☐ BLS Ambulance ☒ Helicopter Service ☐ Private Car

☐ Additional Personnel: ☐ RN ☐ RT ☐ MD ☐ Other

I have been told and understand the risks and benefits of my (the patient's) transfer.

8 ☒ I hereby CONSENT to transfer ☐ I hereby REFUSE transfer

[redacted] Date & Time Witness Date & Time 0155

Patient or Responsible Party

REV. 4-04

Patient Name: HUGHEY, JAMES A.

274,3

Prehospital Care Report

Tippah County Hospital
1005 Highway 15 N
Ripley, MS 38663

Incident Date: 06/07/2017 | Call #: 06171176 | Patient Care #: 1

Patient Information

Name: HUGHEY, JAMES A.

Age: 45 Years
Gender: Male
Weight: 73.800 KG / 160.00 LB

D.O.B: [redacted]
SSN: [redacted]
Race: White

Address: [redacted]

Phone: [redacted]

Ethnicity: Not Hispanic or Latino

Additional Information

Primary Impression	Secondary Impression
Abdominal Pain/Problems	Abdominal Pain/Problems

Narrative

Summary of Events

06/07/2017 the Tippah County Hospital service reported on incident 06171176, call number 06171176. The incident occurrence was at the Public Building (schools, gov, offices) located at address TIPPAH COUNTY SHERIFFS DEPT in the city of Ripley within the county of Tippah of the state of MS. PSAP received the call at 21:32. The unit was notified at 21:32, responded at 21:32, arrived at the scene at 21:34, left the scene at 22:08, arrived at the destination at 22:12 and completed the call at 22:12.

The EMS Crew consisted of Garrett, Shelly who was the Primary Patient Caregiver and Elam, Jeff who was the Driver.

The Agency unit number used was 1104. The Mileage to the scene was 0.60. The Mileage to the destination was 1.00. The use of lights and sirens to the scene was Lights and Sirens.

The use of lights and sirens from the scene was No Lights or Sirens. The response disposition was Treated, Transported by EMS (ALS). The type of service was a 911 Response (Scene).

Factors affecting the delivery of care were Not Applicable, None. Factors affecting dispatch were Not Applicable, None. Factors affecting scene were Not Applicable, None. Factors affecting transport were Not Applicable, None. Factors affecting turnaround were Not Applicable, None.

After arriving at the scene the unit found a patient named JAMES HUGHEY. The patient's approximate age was 45 years. The patient's approximate weight was 73.000 KG. The patient's chief complaint was C/O ABDOMINAL PAIN... NO OBVIOUS DISTENTION OR BRUISING NOTED. The provider's impression was Abdominal Pain/Problems. The use of alcohol and drugs was Smell of Alcoholic Beverage on Breath/About Person. The patient was currently using the medication(s) Glucophage

The following injuries were observed: BRUISING NOTED TO RIGHT SIDE OF FACIAL AREA, PATIENT STATES HIS ABDOMEN IS ALWAYS DISTENDED AND WORSE AT NIGHT. PATIENT STATES THIS IS NORMAL FOR HIM. NEGATIVE TENDERNESS OR DISCOLARED.

Assessment-Adult was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Blood Glucose Analysis was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Capnography was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Cardiac Monitor was performed after 1 attempt at 21:35:00 by crewmember Not

Applicable. The patient's response was Not Applicable. Pain Measurement was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Pulse Oximetry was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Spinal Assessment - No Deficits Noted was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Temperature Measurement was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Spinal Assessment - No Deficits Noted was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Venous Access-Blood Draw was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable. Venous Access-Extremity was performed after 1 attempt at 21:35:00 by crewmember Not Applicable. The patient's response was Not Applicable.

Oxygen by Nasal Cannula 4 LPM Nasal Prongs was given at 21:35:00. The patient's response was Not Applicable. Normal Saline Not Applicable was given at 21:45:00. The patient's response was Not Applicable.

Vitals were taken at 21:35:00. The pulse rate was 102. The respiratory rate was 20. Blood pressure was 111/69. SpO2 was 99. GCS was 14 (Eye = 4, Verbal = 4, Motor = 6).

At an assessment exam returned the following results:
Skin: Cold, Capillary Nail Bed Refill less than 2 Seconds, Dry. Head: Pain/tenderness. Neck: Normal, No JVD noted. Chest: Tenderness-Left, Tenderness-Right. Abdomen-left-upper: Normal (Soft, Non-Tender). Abdomen-left-lower: Normal (Soft, Non-Tender). Abdomen-right-upper: Normal (Soft, Non-Tender). Abdomen-right-lower: Normal (Soft, Non-Tender). Back-cervical: Normal (No Pain or Deformities). Back-thoracic: Normal (No Pain or Deformities). Back-lumbar: Normal (No Pain or Deformities). Ext-right-up: Normal, + C.M.S.. Ext-right-low: Normal, + C.M.S.. Ext-left-up: Normal, + C.M.S.. Ext-left-low: Normal, + C.M.S.. Eyes-left: 3-mmReactive. Eyes-right: 3-mm, Reactive. Mental: Confused , Oriented-Person . Neuro: Normal, Speech Normal.

REQUESTED TO RESPOND TO THE TIPPAH COUNTY SHERIFFS OFFICE- JAIL PER TCSO JAILOR CONCERNED WITH AN INMATE. ON ARRIVAL TO SCENE A 45 YEAR OLD MALE WAS FOUND LYING IN BED WITH A PATENT AIRWAY, NEGATIVE ACTIVE BLEEDING NOTED. THE JAILOR STATED TO EMS CREW HE WAS CONCERNED WITH THE INMATES/PATIENT ABDOMEN DUE TO DISTENTION. PT SLEEPING ON ARRIVAL TO BEDSIDE. PT WOKE FROM A SLEEP AFTER 30 SECONDS OF TRYING TO WAKE HIM. PT HAS A STRONG ODOR OF ALCOHOL WHILE TALKING TO EMS. PT STATES HIS ABDOMEN IS ALWAYS DISTENDED AND WORSE AT NIGHT. UPON PALPATION PT DIDN'T C/O OF ANY PAIN. PT DOES HAVE A BRUISE TO RIGHT CHEEK AREA AND SOME BRUISING TO SHOULDER AND DOWN HIS BACK AREA. PT LAST MEMORY OF THIS DAY WAS IN THE EARLY AFTERNOON. PT STATES HE HAS BEEN DRINKING BEER ALL DAY SINCE THIS MORNING. PT PLACED ON THE EMS COT AND SECURED WITH 3 SEATBELTS FOR TRANSPORT. SEE ALL LISTED PROCEDURES AND VITAL SIGNS NOTED. PT REMAINED AWAKE AND VERY TALKATIVE. PT NEVER C/O OF ANY DISCOMFORT THROUGHOUT TRANSPORT TO TCH ER. PT RECEIVED PER NURSING STAFF WITH VERBAL REPORT GIVEN... ALL FURTHER PT CARE TURNED OVER TO NSG STAFF AT THIS TIME.... SGARRETT, PARAMEDIC

Prior Aid	Performed By	Outcome
	N/A,	N/A

MEDICATION ALLERGIES	Generic Name	Description
NONE		

Patient Medications	Generic Name	Dosage
Glucophage	Metformin HCL	Not Applicable

Medical Surgery History
Not Applicable, Dnf

Patient Name: HUGHEY, JAMES A.

History Primarily Obtained From	Prognosis	Advanced Directives	Practitioner Name

Assessment Exam

Mental Status: Confused, Oriented-Person, ; Neuro: Normal, Speech: Normal, ; Eyes: Rt: 3-mm, Reactive, ; Lt: 3-mm, Reactive; ; Skin: Cold, Capillary Refill: Refill less than 2 Seconds, Dry, ; Head/Face: Pain/Tenderness, ; Neck: Normal, No JVD noted, ; Chest/Lungs: Tenderness-Left, Tenderness-Right, ; LUQ: Normal (Soft, Non-Tender), ; LLQ: Normal (Soft, Non-Tender), ; RUQ: Normal (Soft, Non-Tender), ; RLQ: Normal (Soft, Non-Tender), ; Cervical: Normal (No Pain or Deformities), ; Thoracic(back): Normal (No Pain or Deformities), ; Lumbar: Normal (No Pain or Deformities), ; Extremities: Upper Rt: Normal, + C.M.S., ; Upper Lt: Normal, + C.M.S., ; Lower Rt: Normal, + C.M.S., ; Lower Lt: Normal, + C.M.S., ;

Patient Condition

Chief Complaint: C/O ABDOMINAL PAIN... NO OBVIOUS DISTENTION OR BRUISING NOTED X 1 Days

Secondary Complaint:

Alcohol/Drug Use: Smell of Alcoholic Beverage on Breath/About Person

Injury Date/Time	Injury Cause	Injury Mechanism	Injury Intent	Ht. of Fall
21:32 06/07/2017	Other Injury	Not Available	Unintentional	0

Primary Symptom	Other Associated Symptoms
Not Applicable	Abdominal Pain

Vital Signs

Time	B/P	Pulse	Rhythm	Resp.	Mode	SpO2	SpO2 Qual.	MAP	GCS	Pain	Stroke Vol	PTA	B.G.	BMI	Limb	Patient Position
21:35	111/83	102	RR	20	Normal	99	Low O2	42	14	2			96	17	Right Arm	Semi-Fowlers

ECG/EKG

Time	ECG Type	ECG Lead	ECG Interpretation	ECG Rhythm	Cause For Change

Procedures and Treatments

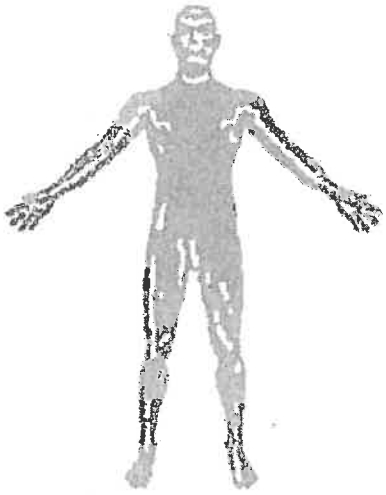
Time	Order Status		Location	Site of Deployment	Attempts	Response	Glucose	Comments
21:35		Assessment-Adult	N/A		1	N/A	N/A	
21:35		Blood Glucose Analysis	N/A		1	N/A	N/A	
21:35		Capnography	N/A		1	N/A	N/A	
21:35		Cardiac Monitor	N/A		1	N/A	N/A	
21:35		Pain Measurement	N/A		1	N/A	N/A	2/10, PATIENT STATES HE ALWAYS HURTS
21:35		Pulse Oximetry	N/A		1	N/A	N/A	
21:35		Spinal Assessment - No Deficits Noted	N/A		1	N/A	N/A	
21:35		Temperature Measurement	N/A		1	N/A	N/A	97.4 ORAL TEMP

Patient Name: HUGHEY, JAMES A.

Time	Done	Name	Location	Size of Equipment	Attempts	Response	Procedure Complication	
21:13 S		Spinal Assessment - No Deficits Noted	N/A		1	N/A	N/A	
21:13 S		Venous Access-Blood Draw	N/A		1	N/A	N/A	
21:13 S		Venous Access-Extremity	N/A		1	N/A	N/A	18G TO LEFT HAND WITH PATENT FLOW

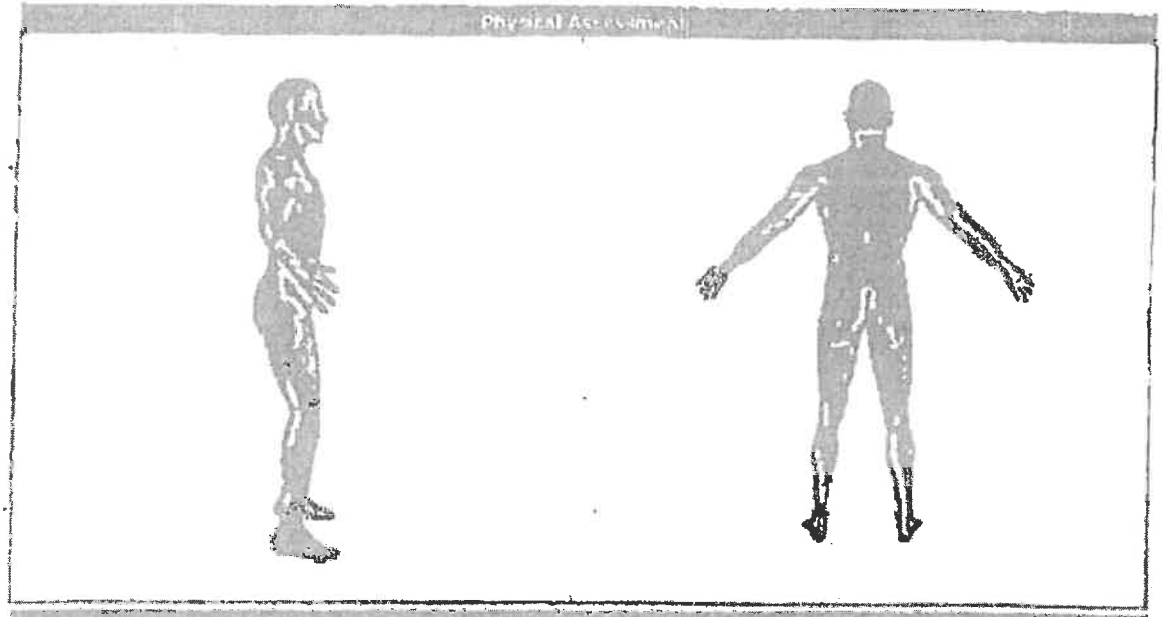
Time	Done	Medication	Route	Devices	Response	PTA	Comments
21:13 S		Oxygen by Nasal Cannula	Nasal Prongs	4 L/M	Not Applicable	N/A	
21:14 S		Normal Saline	Not Applicable	Not Applicable	Not Applicable	N/A	30ML/HR FLOW RATE..

Physical Assessment

Front	Left
	
Right	**Back**

Patient Name: HUGHEY, JAMES A.

Physical Assessment



Injury Details

Injury #	Injury Site	Injury Detail
	Head	Soft Tissue Swelling/Bruising BRUISING NOTED TO RIGHT SIDE OF FACIAL AREA
	Abdomen	Pain without swelling/bruising PATIENT STATES HIS ABDOMEN IS ALWAYS DISTENDED AND WORSE AT NIGHT. PATIENT STATES THIS IS NORMAL FOR HIM. NEGATIVE TENDERNESS OR DISCOLARED

Patient Safety Equipment Used

Not Applicable

Patient Moved To Ambulance | Patient's Position In Transport | Patient Moved From Ambulance

Call Type: Abdominal Pain
Resp. Mode: Lights and Sirens
Urgency: Immediate
Response: 911 Response
Location: Public Building (schools, gov, offices)
Address: TIPPAH COUNTY SHERIFFS DEPT
Ripley, Tippah, MS 38663

Disposition: Treated, Transported by EMS (ALS)
Resp. Mode: No Lights or Sirens
Destination: Tippah County Hospital, 1005 City Ave. N, Ripley, MS
Dest. Specialty Determ.: Resource Center
Diverted: Not Applicable
From:
Response: Not Applicable, Delay: None

1st Resp. Arvl:
PSAP: 21:32 Incident #: 06171176
Disp.: 21:32 Call Sign: 1
Notified:
Unit Disp.: 21:32 Veh. #: 1104
Enroute: 21:32 Start Miles: 0.0
At Scene: 21:34 Scene Miles: 0.6 To Scene: 0.6
At Patient: 21:35
Depart: 22:08
Arrive: 22:12 Dest. Miles: 1.6 To Dest: 1.0
Dest: In: 22:12
Service:

Patient Name: HUGHEY, JAMES A.

	Scene Delay:Not Applicable None Transport:Not Applicable Delay:None	In:22:12 End Miles:1.5 To End:0.0 Quarters: Cancelled:00:00

Crew Member	Level of Certification	Role
Garrett, Shelly (SG)	EMT-Paramedic	Primary Patient Caregiver
Lam, Jeff (JE)	EMT-Basic	Driver

Payment Method:	Work Related?

Occupation	Industry

Valuables

PHILIPS
HEARTSTART MRX
CARDIAC STRIPS
NAME: [illegible] James
DATE: 6-7-17
RUN #: 176

REGIONAL ONE HEALTH
DISCHARGE SUMMARY

Patient Name: HUGHEY, JAMES A
DOB: [redacted]

Account #: 6141230
MR #: 2102258

Race/Sex: CAU/M
Admit Date: 6/8/2017
Dictating Provider: HENKEL, JANE ELYSE

Nursing Unit: 2
Discharge Date: 7/15/2017
Attending Physician: John P. Sharpe, MD

ENC Type: INPATIENT

DICTATING SERVICE: TRAUMA

DISCHARGE DISPOSITION: Home.

DISCHARGE CONDITION: Stable.

DISCHARGE DIAGNOSES:

1. Grade 4 splenic laceration, with pseudoaneurysm.
2. Left rib fractures of 8, 9, and 10.
3. Right ribs 8 and 9 fractures.
4. L1 and L2 transverse processes fractures.

CONSULTING SERVICES:

1. Interventional Radiology.
2. Gastroenterology.
3. Acute pain service.
4. Speech Pathology.
5. Physical Therapy.

OPERATIONS AND PROCEDURES:

1. On June 8th, Interventional Radiology embolization of splenic artery.
2. On June 12th, BAL of the right lower lobe.
3. On June 15th, tracheostomy.
4. On June 17th, toilet bronchoscopy.
5. On June 18th, right chest tube placement.
6. On June 19th, paracentesis.
7. On June 20th, thoracentesis.
8. On June 21st, bronchoscopy with bronchoalveolar lavage of the left lower lobe.
9. On June 27th, EGD.

HOSPITAL COURSE: On June 9, 2017, the patient was admitted to the hospital. He presented as a transfer from an outside hospital with a splenic laceration and rib fractures, status post assault. He was taken to Interventional Radiology for embolization of the splenic artery, and his trauma workup was continued. The patient was found to be increasingly confused, and he required intubation. He was sedated on full vent support for acute respiratory failure with hypoxia. At this time, his white blood cell count was 17.4. His hemoglobin was monitored for post-hemorrhagic blood loss anemia. At this time, his hemoglobin was 8.0, and his hematocrit was 25.1. He was afebrile and was not placed on antibiotics. An ammonia level was checked. DT prophylaxis was initiated due to a history of cirrhosis and chronic alcohol use. Arterial blood gas was obtained, and supportive care was continued. On June 10th, the patient was continued to be intubated and a propofol drip, sedated and will full vent support. The acute pain service was consulted, and he had bilateral rib focus. We continued to monitor his hemoglobin and hematocrit. At this time, his hemoglobin was 6.9, and his hematocrit was 22.2. He continued to be afebrile, with a downtrending white blood cell count at

EXHIBIT
B

REGIONAL ONE HEALTH
DISCHARGE SUMMARY

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DOB: [redacted]

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Admit Date: 6/8/2017
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11.7. His ammonia was found to be elevated at 100, and the patient was started on lactulose and rifaximin. The nutrition service was consulted for tube feeds, and we continued supportive ICU care. On June 11th, the patient was tolerating his tube feeds. Hemoglobin was 8.5, and hematocrit was 25.6. He continued to have a normal white blood cell count at 10.9, although he did spike a fever to 101.9. We continued to monitor his ammonia level and treat it with lactulose and rifaximin. We continued to treat his alcohol withdrawal, and we weaned vent support as tolerated. On June 12, 2017, the patient continued to be febrile at 102.1, and a bronchoscopy with alveolar lavage was performed. At this time, he continued to require ventilator support, and empiric antibiotics were started per trauma protocol at this institution. He was started on Unasyn for the bronchoscopy, and the cultures were followed. On June 12th, the patient continued sedated and requiring ventilator support. Lasix was given for increased interstitial markings on his chest x-ray, and his anemia continued to be stable, with a hemoglobin of 8.6 and a hematocrit of 27.3. Again, he was febrile at 101, and Unasyn was continued. On June 13th, the patient continued to be febrile, with a temperature of 102.5. His white blood cell count was normal at 10.3, and he continued to require sedation, ventilator support, and treatment for elevated ammonia levels. His blood cultures started to grow alpha-hemolytic strep, and Unasyn was continued. On June 14th, the patient continued to be febrile, with a temperature of 12.5. His white blood cell count was 1.3, and the Unasyn was continued. He was still on ventilator support and was requiring Lasix and lactulose. Spironolactone was added. He was noted to have significant ascites, and Gastroenterology was consulted at this time. He was found to have copious watery diarrhea, and his stool was sent for a C diff toxin study. On June 15th, he continued to be febrile, with a maximum temperature of 102.9. His white blood cell count continued to be normal at 8.8, and his cultures continued to grow alpha-hemolytic strep, plus an unknown organism that was yet to be identified. At this time, Interventional Radiology was consulted for paracentesis, and the patient was consent for tracheostomy. A tracheostomy was performed on June 15th, and the patient continued on ventilator support. On June 16, 2017, the patient continued to be febrile, with a maximum temperature of 102.9. His white blood cell count was still normal at 7.6, and he continued to require ventilator support. Per Gastroenterology's recommendation, his spironolactone dose was increased, and a bedside paracentesis was performed by Interventional Radiology which drained 3 liters of fluid that was later sent off for analysis. On June 17th, the patient continued to be febrile at 101.2, and Unasyn was still continued. A toilet bronch was performed on June 17th for continued infiltrate on x-ray. The patient continued to tolerate tube feeds. His hemoglobin remained stable at 7.5, and his white count remained normal at 7.2. His bronchoalveolar lavage culture grew 20 million CFUs of Streptococcus pneumoniae, 2.5 million CFUs of Streptococcus viridans, and continued to be monitored. Blood cultures x2 obtained on June 11, 2017, continued to be negative at this time as well. On June 18, 2017, the patient's tube feeds were placed on hold after an episode of emesis. His NG tube was placed to suction, which suctioned about 3 liters of fluid. Reglan was started per Nutrition's recommendations. The patient continued to be febrile, with a fever of 103.6. Unasyn was continued at this time, and his white blood cell count continued to be normal at 9.1. At this time, the patient only had intermittent agitation. He was followed commands, and continued on Seroquel and Precedex. He continued on ventilatory support with SIMV, and his chest x-ray on this morning showed a right-sided effusion. Hemodynamically, he was stable, and we continued to treat his elevated ammonia levels. On June 19th, the patient continued to be febrile at 102.7, but finished his Unasyn. A right-sided chest tube was placed for a right-sided effusion seen on CT, and the patient was continued on tube feeds and continued to be treated for his elevated ammonia and respiratory needs. On June 20th, the patient continued to be febrile at 102.7. His white blood cell count was 13.5, and his blood cultures continued to be negative. At this time, he was off antibiotics, was

REGIONAL ONE HEALTH
DISCHARGE SUMMARY

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DOB: [redacted]

Account #: 6141230
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Race/Sex: CAU/M
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Dictating Provider: HENKEL, JANE ELYSE

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hemodynamically stable, and his hemoglobin was stable at 8. His chest x-ray showed to be improving, and he was tried on pressure support trials at this time. He also underwent repeat paracentesis with Interventional Radiology, draining 3.5 liters of fluid, as well as thoracentesis, draining 1.3 liters of fluid. On June 21, 2017, the patient continued to be febrile at 103. His white blood cell count was 13.1, and a bronchoscopy with alveolar lavage was performed. Her continued to require ventilator support, although he was tried on spontaneous pressure support trials throughout the day. Per protocol, the patient was started on cefepime and vancomycin. On June 22, 2017, the patient continued to be febrile with a temperature of 101.9. His white blood cell count was 10.6. At this time, his ascetic fluid was negative, his pleural fluid was negative, and his bronchoscopy sample was growing a few gram-negative rods. Hemodynamically, he was table. His chest x-rays were stable. He continued to have intermittent agitation, but was following commands, and we continued to monitor his hemoglobin, which was stable at 9.3. On June 23, 2017, the patient continued to be febrile with a fever of 102.8. His white blood cell count was normal at 7.5, and his cultures continued to be negative at this time. He was continued on vancomycin and cefepime. His hemoglobin continued to be stable at 9.8, with a hematocrit of 29.6, and he continued to receive supportive care in the ICU. Overnight on June 24, 2017, the patient removed both his NG tube and his Dobbhoff tube. He was continued on total parenteral nutrition, and Speech was consulted to evaluate his swallowing abilities. At this time, he was found to be afebrile, with a temperature of 99.6. He was continued on antibiotics, and his white blood cell count was stable at 8.6. His hemoglobin was 9.5 and hematocrit 28.6. At this time, the patient was on high-flow CPAP. His chest x-ray was stable. He was following commands, and his cultures continued to be followed, but were negative at this time with the exception of his blood cultures on June 22nd showing gram-positive cocci in clusters. On June 25, 2017, the patient's blood cultures showed gram-positive cocci in clusters, and his bronchoalveolar lavage sample grew 110,000 CFUs of Pseudomonas aeruginosa. The Pseudomonas was found to be sensitive to cefepime, and he was continued on antibiotics. At this time, his white blood cell count was 9.8, and his hemoglobin was 10.1. On June 27, 2017, the patient underwent an EGD with Gastroenterology. At this time, his blood cultures were found to be most likely a contaminate, and new blood cultures were obtained. His white blood cell count was 9.5, and his hemoglobin was 9.6. He was put back on the ventilator for acute respiratory distress, although his chest x-ray remained unchanged. He continued to follow commands, and he continued to be afebrile. On June 18th, the patient was placed back spontaneous on the vent. Vancomycin was discontinued, and he was continued on cefepime. His white blood cell count at this time was 10.4, and his hemoglobin was 9.7. On June 29th, the patient was transitioned back to high-flow CPAP. His chest x-ray remained unchanged, and he was continued on total parenteral nutrition. He failed a modified barium swallow per Speech Therapy and was only approved for ice chips at this time. He continued to be afebrile, with a maximum temperature of 99.7, and his white blood cell count continued to be normal at 8.9. His hemoglobin was stable at 9.0. On June 30th, the patient continued on cefepime and treatment for elevated ammonia levels, which were now down to 57. He continued to be afebrile. His white blood cell count was 8.5, and his anemia was stable with a hemoglobin of 9.0. He continued on high-flow CPAP. His chest x-ray remained unchanged, and he was tolerating his tube feeds, and total parenteral nutrition began to be weaned. His EGD showed no active bleeding, and Lovenox was started for DVT prophylaxis. On July 1st, the patient spiked a low-grade fever of 100.7. He was continued on cefepime. At this time, his white blood cell count was 9.8, and his hemoglobin was stable at 10. On July 2nd, the patient continued to have a low-grade fever of 99.9. His white blood cell count was 10.5, and his hemoglobin was stable at 10.6. He continued on cefepime for the Pseudomonas in his bronchoalveolar lavage culture, and he was continued on high-flow CPAP at this time. His ammonia level was found to be trending upward to 113 from 60 just 2 days prior, and his lactulose dosage was

REGIONAL ONE HEALTH
DISCHARGE SUMMARY

Patient Name: HUGHEY, JAMES A
DOB: [redacted]

Account #: 6141230
MR #: 2102258

Race/Sex: CAU/M
Admit Date: 6/8/2017
Dictating Provider: HENKEL, JANE ELYSE

Nursing Unit: 2
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increased. On July 3, 2017, the patient continued to be weaned to a trach collar, requiring intermittent high-flow CPAP for respiratory distress. He continued to be afebrile, with a T-max of 99.2. He continued on his cefepime, with a white blood cell count of 10.5 and a hemoglobin of 10.6. We continued tube feeds, and his blood cultures were deemed final. On July 4, 2017, we continued weaning to a trach collar. His T-max was 99.6. We continued cefepime for Pseudomonas in the cultures. The patient's white blood cell count was 12.7. His hemoglobin was stable at 10.8. He was found to be agitated, and we started him on Seroquel. The tube feeds were continued. Lasix, rifaximin, Aldactone, and lactulose were continued. His ammonia level continued to be trended. On July 5, 2017, the patient continued to be afebrile, with a T-max of 99.3. Today was his last day of cefepime. His white blood cell count was 12.7, with his hemoglobin stable at 10.8. His agitation improved with Seroquel, and he was successfully weaned to a trach collar, breathing aerosolized FIO2 at 28%. His chest x-ray this morning showed no effusions, infiltrates, or pneumothoraces. His was tolerating her tube feeds, and we continued on treatment for his elevated ammonia, which was 81 today and improving. On July 6, 2017, the patient's maximum temperature was 100.3. He was no longer on cefepime. His white blood cell count was 13.3, with a stable hemoglobin at 10.6. The patient's agitation continued to improve, as well as his respiratory status. He was tolerating the trach collar well, and he was downsized to a size 6 cuffed trach. He was also witnessed walking in the halls of PT and tolerating that well. On July 7, 2017, the patient continued to be afebrile, with a temperature of 98.6. He was not on antibiotics. His white blood cell count was down from 13.3 to 11.6. He continued on Seroquel for agitation. He had failed his modified barium swallow, so we continued tube feeds, and we continued on treatment for his ammonia levels that continued to fluctuate. On July 8th, the patient continued to be afebrile and tolerating the trach collar well. He was switched to a 6 cuffless trach. He continued on Seroquel. His ammonia levels continued to trend downward, and his white blood cell count was 9.6, with a hemoglobin stable at 10.4. On July 9, 2017, the patient continued to be afebrile, without a white count. His hemoglobin was stable. He was now tolerating nasal cannula at 2 liters and started on capping trials with Speech Therapy. His ammonia levels continued to improve, and he continued to work with Physical Therapy. On July 10th, the patient was afebrile and without a white count. His hemoglobin was stable at 9.0, and he was together room air. His trach was capped at this time in preparation for decannulation on July 11th. On July 12th, the patient ambulated well with Physical Therapy. He was up in a chair for most of the day and continued to have a low ammonia level. He was decannulated. He was afebrile, with a white blood cell count of 8.5 and hemoglobin stable at 10.2. We continued to monitor him in the progressive care unit. On July 13th, the patient continued to be afebrile and without a white count. His hemoglobin was stable at 10.9, and his ammonia was stable. On July 14th, the patient remained oriented, without agitation or confusion. He was tolerating room air. His hemoglobin remained stable. He remained without a white count and continued to be afebrile. On July 15, 2017, the patient continued to improve. He was afebrile and without a white count, with a hemoglobin of 10.8. He was discharged home with family.

DISCHARGE INSTRUCTIONS: The patient was discharged on a regular diet and told to follow up if he experienced any worsening confusion, pain, fevers, or any other life-threatening condition. His activity was unrestricted, and he returned home with family.

This document is considered preliminary until authenticated by the attending physician.

REGIONAL ONE HEALTH
DISCHARGE SUMMARY

Patient Name: HUGHEY, JAMES A
DOB: [redacted]

Race/Sex: CAU/M
Admit Date: 6/8/2017
Dictating Provider: HENKEL, JANE ELYSE

Account #: 6141230
MR #: 2102258

Nursing Unit: 2
Discharge Date: 7/15/2017
Attending Physician: John P. Sharpe, MD

ENC Type: INPATIENT

Edited By HENKEL, JANE ELYSE MD 31-Jul-2017 09:13:16 -05:00

Electronically Signed By HENKEL, JANE ELYSE MD on 31-Jul-2017 09:13:18 -05:00
Electronically Signed By MAGNOTTI, LOUIS J. MD on 31-Jul-2017 12:52:32 -05:00

HENKEL, JANE ELYSE

201047 / kl
DD: 7/21/2017 5:45:00 PM
TT: 7/24/2017 9:12:31 PM
Job #: 0199636

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
OXFORD DIVISION

JAMES ALLEN HUGHEY — **PLAINTIFF**

VERSUS — **CIVIL ACTION NO:** 3:18cv004-NBB-RP

TIPPAH COUNTY, MISSISSIPPI,
TOMMY MASON, in His Individual Capacity,
and "X" Bonding Company — **DEFENDANTS**

JURY TRIAL DEMANDED

COMPLAINT

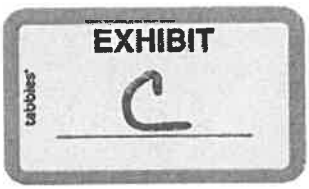
This is an action to recover actual and punitive damages for use of unreasonable force in violation of the Fourth Amendment to the United States Constitution. The following facts support the action:

1.

Plaintiff JAMES ALLEN HUGHEY is an adult resident citizen of 332 Old Highway 4, Ashland, Mississippi 38603.

2.

Defendant TIPPAH COUNTY, MISSISSIPPI is a political subdivision of the State of Mississippi. Defendant County may be served with process upon its Chancery Clerk, Mike Long, 101 East Spring Street, Ripley, Mississippi 38663, and upon its Sheriff, Karl Gaillard, 205 West Spring Street, Ripley, Mississippi 38663. The County is the same entity as the Sheriff of Tippah County in his official capacity.



Defendant TOMMY MASON is an adult resident citizen of Mississippi. He may be served with process at 205 West Spring Street, Ripley, Mississippi 38663. At all relevant times, Defendant Mason was a deputy sheriff assigned to the narcotics and investigation division by Defendant Tippah County, Mississippi. Defendant Mason was on duty twenty-four (24) hours a day and, at all relevant times, acted under color of state law.

Defendant "X" is the bonding company which guaranteed faithful performance of duty by the Sheriff of Tippah County, Mississippi and his deputies.

3.

The Court has federal question jurisdiction under 28 U.S.C. § 1331 and civil rights jurisdiction under 28 U.S.C. § 1343, for a cause of action authorized by 42 U.S.C. § 1983. This case is based on actions taken in violation of the Fourth and Fourteenth Amendments to the United States Constitution. This Court has supplemental jurisdiction over Plaintiff's state law claims of assault and battery against Mason and "X" Bonding Company. This Court will have supplemental jurisdiction over the state law claims against the County (the Sheriff in his official capacity) upon expiration of the statutory waiting period with respect to a Notice of Claim, to be given to the County.

4.

For a substantial period of time before June 6, 2017, Defendant Mason, acting under color of his office as a Deputy Sheriff, had engaged in activities which either alerted the Sheriff of Defendant Tippah County or, except for gross negligence by the Sheriff, would have alerted the Sheriff to the fact that Defendant Mason is a dangerous person who should not be employed in law enforcement. The previous incidents include:

A. Defendant Mason's ex-wife, Amanda Mason, a/k/a Amanda Crumpton, alleged that Defendant Mason had beaten her. She attempted to obtain law enforcement assistance from Defendant Tippah County;
B. Defendant Mason had beaten a man named Joseph Smithey based upon a rumor that Smithey was engaged in a relationship with Defendant Mason's ex-wife;
C. Defendant Mason had struck an arrestee, April Johnson, in the mouth, and slammed her head on a truck, knocking out several teeth;
D. Defendant Mason had broken the nose of Kristen Hopkins;
E. Defendant Mason had beaten a sixteen (16) year old undocumented immigrant named Jamie Guerrero;
F. Defendant Mason had beaten Richey Beeler;
G. Defendant Mason had been involved in a police killing of a suspect in Dumas, Mississippi. Defendant Mason had bragged that he had "finished off" the suspect after another officer had shot him;
H. Defendant Mason had beaten Jeremy Palmer; and
I. Defendant Mason had beaten Brian Lansdale.

These acts are such as to render Defendant County liable for Mason's acts of assault on the grounds that Mason's beatings constitute Defendant County custom and policy of violating the Fourth Amendment prohibition against unreasonable use of force.

5.

In addition to the assaults which Defendant Mason committed, there was substantial reason to believe that Defendant Mason was involved in unlawful drug activity, and used performance enhancing drugs, including steroids. Defendant Mason has such an extreme muscular development, that it is likely that his strength and rage are the result of use of unlawful drugs. Defendant Mason frequents a gym known for steroid-induced muscle-building. Defendant Mason is a customer of a drug store and doctor's clinic which have been determined by governmental authorities to be engaged in the unlawful distribution of drugs.

6.

Because of a combination of the numerous incidents of unreasonable force and likelihood that Defendant Mason was utilizing performance-enhancing drugs known to cause rage, Defendant County, acting through its Sheriff, should have known that Defendant Mason was unfit for law enforcement. Defendant Mason should not have been retained as a law enforcement officer. Failure to discharge Mason proximately caused Plaintiff's injuries, and renders Defendant County liable under 42 U.S.C. § 1983.

7.

Plaintiff suffers from a number of serious medical conditions, including diabetes, liver disease, and ammonia poisoning. These conditions cause Plaintiff, who is a physically weak person, to become disoriented, and to be unaware of what he is doing.

8.

On or about June 6, 2017, Plaintiff went to a home where he believed his ex-girlfriend resided. The home was, in fact, occupied by his ex-girlfriend's mother, Brenda Crumpton, and, possibly, by Defendant Mason's ex-wife, Amanda Mason.

9.

Plaintiff recalls knocking on the door at the home, after which he was beaten by Defendant Mason. Because of Plaintiff's preexisting medical conditions, because he suffered from a loss of orientation, and because of the severity of his injuries, Plaintiff has little memory of the events.

10.

The beating was carried out by Defendant Mason for reasons unknown to Plaintiff, but probably because of steroid-induced rage. Defendant Mason left the scene before any other law

enforcement officer of Defendant Tippah County arrived.

11.

After the beating, another law enforcement officer employed as a Tippah County Deputy Sheriff arrived at the scene and arrested Plaintiff. Defendant County initially delayed medical treatment but, after the intervention of Plaintiff's family, agreed to take Plaintiff to the hospital in Ripley, Mississippi. Plaintiff's life was in danger, and the local hospital caused him to be air-transported to The Med in Memphis, Tennessee. Plaintiff's injuries included, but are not limited to, approximately seven (7) broken ribs, internal bleeding, contusions, and abrasions. Plaintiff's life was in danger, and he was treated in intensive care for approximately one week at The Med in Memphis.

12.

Defendant Mason's beating of Plaintiff constituted unreasonable use of force in violation of the Fourth Amendment to the United States Constitution. It also constituted assault and battery, which is a crime under State law, and for which Mason and "X" Bonding Company are liable.

13.

Following the beating, the Sheriff knew, or reasonably should have known, that Defendant Mason was guilty of the beating. Nevertheless, Defendant County ratified Defendant Mason's acts by retaining him as a law enforcement officer.

14.

Plaintiff has incurred medical bills and has incurred pain and suffering as a result of the unreasonable use of force and assault and battery by Defendant Mason.

15.

Defendant County is liable to Plaintiff for the acts of Defendant Mason because, in willful indifference to Plaintiff's rights, Defendant County, through gross negligence, hired and/or retained Defendant Mason as a law enforcement officer. Further, Defendant County has ratified Defendant Mason's actions by retaining him as a law enforcement officer when it knew, or except for gross negligence, should have known about Defendant Mason's beating Plaintiff.

16.

Defendant County knew or, except for gross negligence, would have known about Defendant Mason's steroid use, or reasonably should have known that he was apt to go into rages because of that steroid use. Retaining Defendant Mason as a deputy was, therefore, a violation of Plaintiff's Fourth and Fourteenth Amendment rights.

17.

Additionally, Defendant County is liable under state law because of its negligence in hiring or retaining Defendant Mason, and also because it has ratified Defendant Mason's acts by retaining him as a police officer. Plaintiff does not yet make the State law claim because under State law, Defendant County is entitled to receive notice of State claims, and an opportunity to resolve them before the filing of suit. Once the statutory waiting period has expired, and assuming the State law claims have not been resolved during that waiting period, Plaintiff requests this suit be amended to allege State law violations.

18.

Plaintiff, therefore, sues and requests actual and punitive damages against Defendant Mason, individually, and "X" Bonding Company, in an amount to be determined by a jury for violation of

Plaintiff's Fourth and Fourteen Amendment rights, and for assault and battery under State law. Plaintiff also requests actual damages against Defendant County for violations of the Fourth Amendment because it has been grossly negligence and willfully indifferent to the rights of citizens by retaining Defendant Mason in his employment knowing of his steroid use and his previous record of assaults and battery.

REQUEST FOR RELIEF

Plaintiff requests actual and punitive damages against Defendant Tommy Mason and "X" Bonding Company, and actual damages against Defendant Tippah County, Mississippi, in an amount to be determined by a jury. Plaintiff also requests reasonable attorney's fees, costs and expenses under 42 U.S.C. § 1988. Tippah County is now sued for federal violations only. If the County fails to settle the State law claims within the waiting period required by State law, Plaintiff requests that the Complaint be amended to sue the County for State law violations.

Respectfully submitted, this the 4th day of January, 2018.

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